



# MONTEREY COUNTY BEHAVIORAL HEALTH

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Avanzando Juntos Forward Together

The County of Monterey  
Community Planning Process Report  
**FY 2025–2026**

Prepared by:

**EVALCORP**  
Measuring What Matters<sup>SM</sup>

# Table of Contents

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**TABLE OF CONTENTS..... II**

**ACKNOWLEDGEMENTS ..... III**

**MONTEREY COUNTY BEHAVIORAL HEALTH FY 25-26 COMMUNITY PROGRAM PLANNING  
PROCESS AT A GLANCE ..... 1**

**INTRODUCTION ..... 3**

**METHODS ..... 4**

**ENGAGEMENT STRATEGY..... 4**

**DATA COLLECTION ..... 4**

**DATA ANALYSIS ..... 5**

**KEY THEMES AND FINDINGS ..... 5**

**BEHAVIORAL HEALTH NEEDS, SERVICES, AND ACCESS..... 6**

**BARRIERS TO SERVICES ..... 10**

**RECOMMENDATIONS FOR BEHAVIORAL HEALTH SERVICES ..... 13**

**PARTICIPANT DEMOGRAPHICS..... 16**

**SUMMARY ..... 19**

# Acknowledgements

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Lastly, we would like to acknowledge and thank the Monterey County community for participating in the Community Behavioral Health Survey and sharing their experiences, stories, and recommendations during the Listening Sessions. This report would not be possible without them.



# At a Glance

Prepared by:  
EVALCORP

## FY 2025-2026 Community Program Planning Process



**652**

survey submissions



**326**

listening session attendees



**43%**

of survey respondents reported  
daily mental health challenges

### Recommendations Based on BHSA Component

#### Housing

Increase the County's affordable housing inventory

Expand housing support services for individuals with behavioral health conditions

Offer and strengthen financial assistance programs

Improve and streamline housing policies

Provide long-term support and skill-building opportunities

#### Full-Service Partnerships

Integrate behavioral health care with housing services

Provide direct transportation assistance

### Behavioral Health Services and Supports

Scale up community-based services and peer support models

Expand crisis and prevention services

Broaden the availability and types of services for youth and families

Hire and retain care providers who reflect the cultural and linguistic backgrounds of the communities served

Increase translation and interpretation services, prioritizing Indigenous languages

Enhance cultural competence among staff and providers

# Findings: At A Glance

## General Observations



### Overall

- The CPPP assessment highlighted that there is no universal experience when it comes to the behavioral health care system. Feedback from a wide range of participants indicated that how someone views services depends heavily on their own life journey.



### Providers and Community Members

- People who provide care and those who receive care often see the system differently. Both viewpoints are essential to understanding how the care system functions in real-world settings.



### Community Identities

- Certain groups have distinct experiences that differ from the general public. Specifically, individuals facing housing challenges, those insured by Medi-Cal, and those who primarily speak Indigenous languages shared unique concerns that require focused attention.

## Top Behavioral Health Issues

- Anxiety
- Alcohol Use Disorder
- Trauma

## Views on Service Availability

- Shortage of services for people seeking help with mental health or substance use.
- Lack of housing assistance for people managing mental health or substance use challenges.

## How Easy is it to Get Help?

- ~ 40% feel mental health and substance use care is accessible
- ~ 21% feel housing support is accessible to people managing mental health or substance use challenges

## Barriers to Mental Health and Substance Use Care

Key Area	Type of Barriers
Finances and Accessibility	Costs of care; lack of childcare/support; transportation challenges; long waits; limited hours.
System & Service Challenges	Difficult-to-navigate systems; provider shortages; inconsistent quality of care.
Social & Cultural Factors	Language and cultural mismatches; readiness for treatment; stigma around mental health and substance use.

## Barriers to Housing Support

Key Area	Types of Barriers
Financial Pressures	High rent and utility costs; limited income; lack of affordable units.
System & Administrative Barriers	Complex applications and referrals; long waitlists and limited supply; difficult move-in processes.
Social & Mental Health Challenges	Housing instability and mental health issues reinforcing each other; discrimination; stigma.

# Introduction

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The Mental Health Services Act (MHSA), approved by California voters in 2004, funded behavioral health services through a 1% tax on personal income over \$1 million per year.<sup>1</sup> The purpose of the act was to expand and transform California's behavioral health services to better support individuals with, or at risk for, serious mental health conditions, and their families. The MHSA addressed a wide range of prevention, early intervention, and treatment needs, as well as the infrastructure, technology, and workforce development necessary to sustain an effective public behavioral health system.

To ensure MHSA funds met the diverse needs of communities, the Mental Health Services Oversight and Accountability Commission (MHSOAC) required counties to create a Three-Year Program and Expenditure Plan and Annual Updates. These plans were developed through a Community Program Planning Process (CPPP), which gathered input from Community Members (individuals who use or may benefit from behavioral health services) and Providers (those who provide or coordinate services) to guide priorities and improvements.

Beginning in July 2026, the Behavioral Health Services Act (BHSA) will replace MHSA. BHSA places a greater focus on providing complete care (mental health, substance use treatment, housing, and other supports) for people who need it the most. Counties are required to establish an Integrated Plan<sup>2</sup> that describes the services to be provided and outlines where all public funds for behavioral health will be allocated over the next three years. This first Integrated Plan is to be developed by March 31, 2026, prior to the transition to BHSA.

The CPPP remains a central requirement to BHSA planning and development of the Integrated Plan. The process is designed to ensure counties actively partner with Community Members and Providers across all operational phases: policy development, program planning and implementation, monitoring, workforce planning, quality improvement, and budgeting.

To support the development of the first BHSA Integrated Plan, Monterey County Behavioral Health (MCBH) engaged local groups using various methods to fulfill the CPPP mandate. Two of the activities in support of the CPPP, and included in this report, were a community behavioral health survey and listening sessions.

This report focuses specifically on the survey and listening session findings and does not include any other community planning activities hosted by MCBH. MCBH contracted EVALCORP, an evaluation firm, to conduct the survey and listening sessions with Community Members and Providers, gathering critical data to align behavioral health services with community needs.

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<sup>1</sup> [Department of Health Care Services, "Mental Health Services Act"](#)

<sup>2</sup> [Behavioral Health Service Act County Policy Manual](#)

# Methods

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## Engagement Strategy

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The BHSa CPPP requires counties to engage specific stakeholders meaningfully to ensure equitable access to culturally responsive services<sup>3</sup>. A total of 19 stakeholder groups were engaged through surveys and listening sessions.

- Individuals with lived experience
- Veterans
- Emergency medical services
- Education agencies
- Medi-Cal Managed Care Plans
- Community-based organizations serving diverse populations
- Higher education partners
- Independent living centers
- Veteran Organizations
- Families
- Youth organizations
- Public safety partners
- Health care organizations
- Tribal representatives
- County social services and child welfare agencies
- Early childhood organizations
- Disability insurers
- Aging agencies
- Providers of mental health and substance use disorder services

## Data Collection

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### Community Survey

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The community survey was designed to capture insights on behavioral health issues from both Community Members and Providers. MCBH coordinated a distribution strategy, working with partner agencies and organizations to share the survey with their clients, Providers, and the broader community through approximately 80 channels. To ensure representation across Monterey County's diverse population, survey response patterns were continuously monitored, and targeted outreach was conducted, utilizing both online and hard-copy formats. These efforts resulted in 652 survey respondents.

### Listening Sessions

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A series of listening sessions were conducted to gather community perspectives on service needs and ideas on how BHSa funds should be used. These sessions were open to all Monterey County residents, with a mix of Providers and Community Members attending. MCBH partnered with local agencies and organizations to conduct outreach throughout the County. Participants were asked to complete the Community Survey during the session. Approximately 326 individuals<sup>4</sup> participated in eight listening

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<sup>3</sup> [Department of Health Care Services, Community Planning Process and Local Stakeholder Engagement](#)

<sup>4</sup> Virtual listening sessions allow for participation by non-County residents. To ensure data from any particular Listening Session did not qualitatively differ from the other sessions, data for each Listening Session were analyzed and validated separately, confirming their consistency with the year's overall findings. After review and validation, all data were analyzed together for inclusion in the report.

sessions (four virtual and four in-person). Sessions were offered in English, Spanish, Mixteco, and Triqui. All sessions were available in Spanish, either through primary facilitation or interpretation.

## Data Analysis

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Following data collection, the 652 survey responses yielded by the distribution strategy were prepared for analysis. The data was first analyzed for all survey respondents, then separated into two main groups: those who provide services (Providers) and those who may use services (Community Members).

The data were then further broken down across the following characteristics to identify group-specific findings:

- Age
- Identity<sup>5</sup>
  - Living with a mental health or substance use disorder
  - Living with housing support needs
  - Family member of a person with support needs
  - Living with a disability or chronic health condition
  - LGBTQ+
  - Survivor of domestic violence and/or sexual assault
- Insurance type
- Primary language

Demographic data from survey participants were analyzed using descriptive statistics to provide a comprehensive understanding of respondents' identities.

All qualitative data from the listening sessions were cleaned and prepared for analysis, which flowed through two phases. The first phase involved a qualitative content analysis to identify prominent themes. In the second phase, themes were synthesized, analyzed, and summarized in this document. Direct quotes were used to illustrate main themes. To keep the focus on key findings, some quotes were edited using ellipses (...) for removed words and brackets [ ] for substituted text or contextual information, as needed. However, care was taken to ensure the participant's original message and meaning remained unchanged.

## Key Themes and Findings

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The findings described in this report reflect the community's perspectives on mental health, substance use, and housing for those living with mental health and/or substance use issues, as well as access to services. CPPP participants shared their perceptions of community concerns, service availability, and barriers to accessing services. Communication preferences, feedback on existing services, and recommendations for future services were also provided. These insights reflect the community's view of the current state of behavioral health services in Monterey County and highlight considerations for BHSA funding.

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<sup>5</sup> Identity subgroups are not separate, as participants could select multiple options.

# Behavioral Health Needs, Services, and Access

## Priority Mental Health and Substance Use Issues

Respondents were asked to identify the most important mental health and substance use issues in their community (see Figure 1). Anxiety, alcohol use disorder, and trauma were ranked as the top three issues within Monterey County overall, as well as among Community Members and Providers.

Subgroup analysis for personal identity and age revealed similarities in leading behavioral health concerns, though the order of priority differed. Chronic stress was a highly ranked issue for individuals living with housing needs (n=38), living with a disability or chronic health condition (n=28), and identifying as LGBTQ+ (n=21).

**Figure 1. Priority Mental Health and Substance Use Issues**



Figure 1: The first column shows the top 5 concerns identified by all survey respondents (1=most important). The other columns show how different subgroups ranked these same 5 concerns. The lines show how priorities change from group to group.

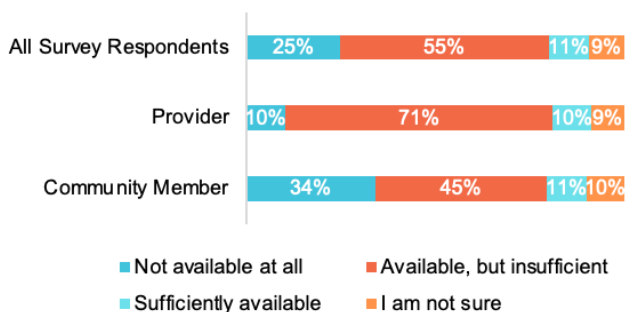
Overall, the findings highlight pervasive community challenges and identify several key areas for intervention. While there was broad consensus on the top behavioral health issues, several subgroups uniquely identified chronic stress as a primary concern. This differential finding strongly emphasizes the importance of ensuring programming considers the diverse needs present within the community.

## Availability of Services

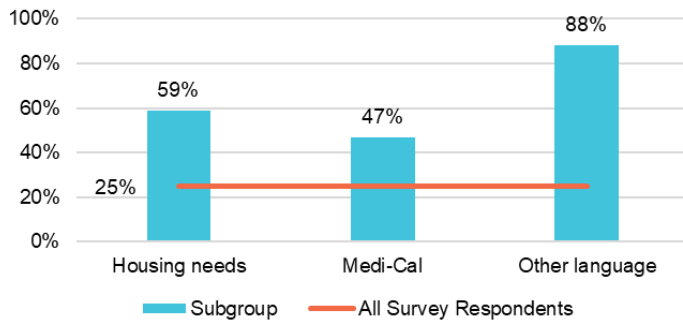
### Mental Health Services

When asked about the sufficiency of services addressing mental health needs, many respondents expressed concern. Over half (55%, n=347) of all survey respondents indicated that mental health services exist, but they are insufficient to meet community needs. This perception of insufficiency was more pronounced among Providers (71%, n=173) than among Community Members (45%, n=174) (Figure 2).

**Figure 2. Ratings of Mental Health Service Availability**



**Figure 3. Perceptions of Unavailable Mental Health Services**

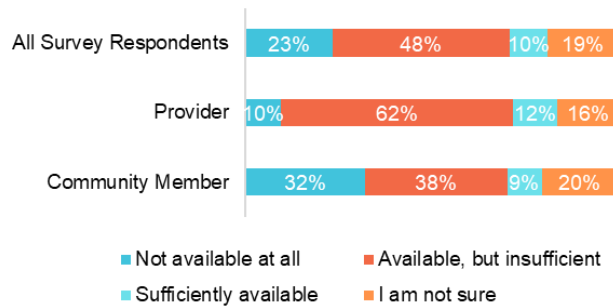


The majority of subgroups shared the overall finding that mental health services were inadequate to meet community needs. However, a significant contrast was found among specific groups: most individuals requiring housing support (n=39), those insured by Medi-Cal (n=98), and those who primarily spoke a language other than English (typically an Indigenous language) (n=112) reported that mental health services were nonexistent in Monterey County (Figure 3).

**Substance Use Services**

A significant number of respondents expressed concern when evaluating the availability of substance use services. Overall, 48% of respondents (n=295) believed services were insufficient to meet community needs. This perception was less common among Community Members (38%, n=144) than among Providers (62%, n=151) (Figure 4).

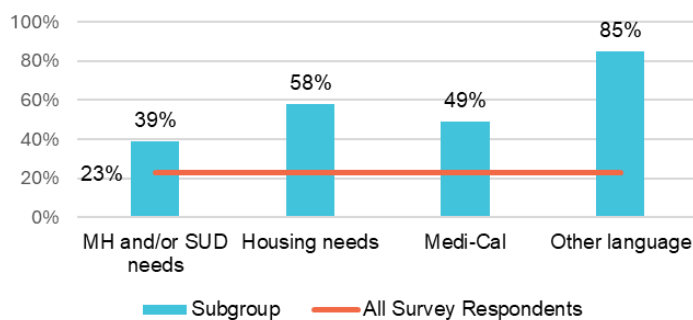
**Figure 4. Ratings of Substance Use Service Availability**



The sub-analysis generally aligned with the overall results, indicating that most subgroups viewed substance use services as insufficient. Notable differences emerged for several key

groups: individuals with mental health or substance use disorder (n=77), living with housing needs (n=38), insured by Medi-Cal (n=100), and whose primary language was not English (often an Indigenous language) (n=109) were more likely to perceive substance use services as completely unavailable in the County (Figure 5).

**Figure 5. Perceptions of Unavailable Substance Use Services**

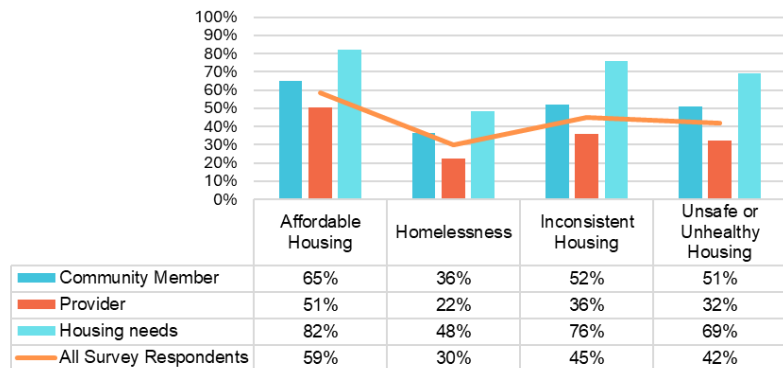


**Housing Services**

To identify housing service gaps for individuals with substance use disorder and/or mental health challenges, survey respondents evaluated the availability of various housing-related services in the County. Overall, very low proportions of respondents (5-10%) considered any housing services to be readily available. Affordable housing services were universally identified as the least available service, a

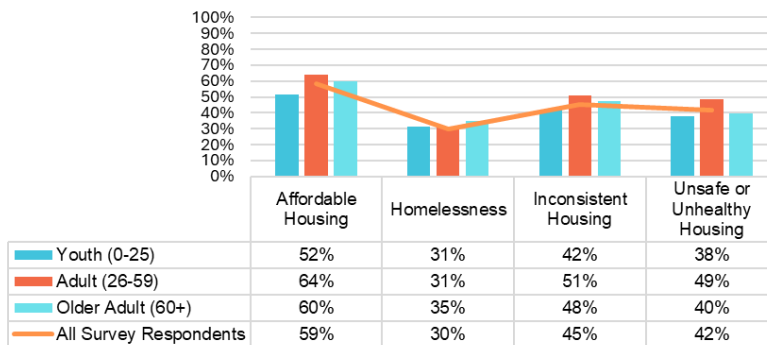
view shared by Community Members, Providers, and most subgroups. While most Community Members indicated a lack of services across all other housing-related needs, Providers were less likely to report this widespread unavailability. The sub-analysis highlighted a key difference in identity: those with housing needs reported a considerably higher perception of service unavailability compared to the overall respondent collective (Figure 6).

**Figure 6. Perceptions of Housing-Related Services as Unavailable**



While perceptions of absent services across age categories generally aligned with the overall survey

**Figure 7. Perceptions of Unavailable Housing-Related Services by Age**



findings, a closer examination revealed some distinctions. Adults consistently reported the highest rates of service unavailability across all housing issues except homelessness. For homelessness, which was the least critical concern for all age groups, older adults (n=21) were the most likely group to view these services as unavailable (Figure 7).

Overall, the findings indicate that although residents are generally aware of available behavioral health and housing services in Monterey County, many, especially Providers and vulnerable populations, perceive significant gaps or complete absences in service capacity. These perceptions may be limiting referrals, reducing utilization, and discouraging care-seeking. This highlights an opportunity for additional outreach and education on available services.

## Communication Preferences for Receiving Service Information

Given the perceptions of significant behavioral health service gaps, understanding how residents prefer to receive information about available resources is essential to ensuring that those most in need can receive care. The following results describe the communication preferences of survey respondents, revealing which channels may be most effective for broad outreach and those necessary for targeted engagement. Overall, survey respondents indicated they preferred to receive information about behavioral health services through social media. While social media and email were the dominant choices across subgroups, there were variations in preferences for those insured through Medi-Cal coverage and whose primary language is another language (often Indigenous languages) (Table 1).

**Table 1. Preferences for Receiving Service Information**

	Email	Newsletters	Phone	Podcasts/ Videos	Radio	Social Media	Television	Text/ WhatsApp	Websites	Other**
<b>All</b>						<b>42%</b>				
Community Member						33%				
Provider	<b>54%</b>									
Youth (0-25)						<b>64%</b>				
Adult (26-59)	<b>39%</b>					39%				
Older Adult (60+)	<b>49%</b>									
Medicare	<b>52%</b>									
Medi-Cal								<b>36%</b>		
Private Insurance	<b>53%</b>									
Uninsured						<b>50%</b>				
Prefer not to answer						<b>50%</b>				
English	<b>63%</b>									
Spanish						<b>47%</b>				
English and Spanish						<b>70%</b>				
Other Language										<b>44%</b>
Prefer not to answer									<b>57%</b>	

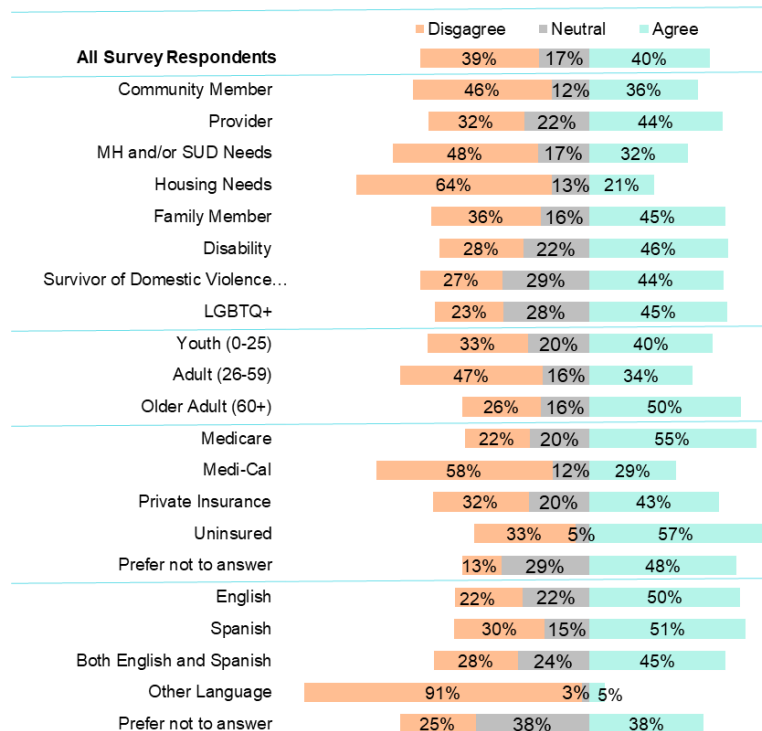
Darker shades indicate a higher percentage of respondents selected that mode of communication, while lighter shades indicate a lower percentage. The highest percentage for each subgroup is included in dark, bold text.

\*Other communication options included physical mail, newspapers, in-person (e.g. workshops, community events), and word of mouth.

This data indicates that digital methods are generally effective; however, channels such as physical mail are crucial for effectively engaging specific, high-need populations, particularly those with language differences or socioeconomic barriers.

## Service Accessibility

**Figure 8. Perceived Access to Mental Health and Substance Use Services**  
Agreement with the statement:  
"In my community, people with mental health and substance use needs can get help."

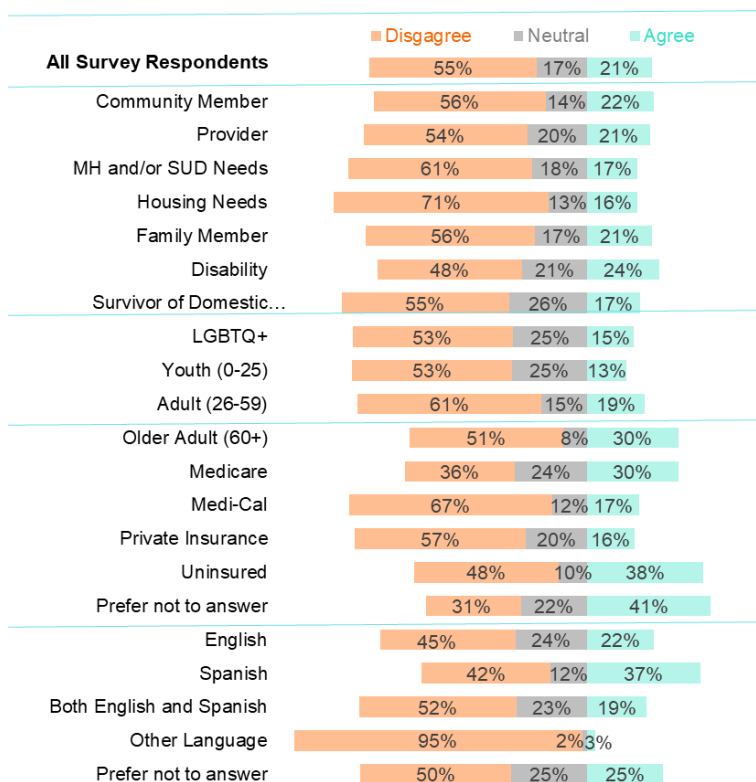


To understand community perceptions of behavioral health care accessibility in Monterey County, survey respondents were asked whether people with mental health and substance use needs could access help and housing support in their community. The findings indicate that approximately 40% of all respondents agreed that mental health and substance use services were accessible. This view varied slightly by respondent identity, with Providers reporting greater access and Community Members reporting lower access. Subgroup analysis further highlighted that three groups, individuals living with housing-support needs (21%, n=12), those with Medi-Cal insurance (29%, n=59), and Indigenous language speakers (Other language) (5%, n=6) held considerably lower perceptions of service accessibility compared to the overall response (Figure 8).

Perceptions of accessibility to housing services were generally low, with over half of survey respondents believing individuals with mental health and substance use needs could not access housing support. The perceptions of Community Members and Providers were consistent with the collective. The perceived service gap was highest among those insured by Medi-Cal (67%, n=137), experiencing housing needs (71%, n=39), and whose primary language was not English or Spanish (primarily Indigenous languages) (n=110, 95%), who indicated that they could not receive local assistance (Figure 9).

The consistent, low confidence in receiving behavioral health and housing support implies a disconnect between community demand and effective supply in Monterey County. The vastly higher perceptions of inaccessibility among the highest-need groups, like those with housing needs, Medi-Cal recipients, and Indigenous language speakers, indicate significant barriers and/or communication gaps are impeding access to care for the most vulnerable.

**Figure 9. Perceived Access to Housing Support Service**  
 Agreement with the statement:  
*"In my community, people with mental health and substance use needs can get the support they need to find housing."*



## Barriers to Services

The following section explores the barriers Monterey County residents face when accessing mental health, substance use, and related housing services for individuals experiencing these challenges. The findings provide insight into views on service availability and accessibility.

### Mental Health and Substance Use Services

The cost of services, lack of childcare/caregiver support, and stigma were the most common barriers to accessing mental health and substance use services for all survey respondents, including Community Members and Providers. Sub-analyses of responses revealed differences in challenges faced by specific populations. Notably, nearly three-

**Table 2. Barriers to Accessing Mental Health and Substance Use Services**

	All Survey Respondents	Community Member	Provider	MH or SUD Needs	Housing Needs
Cost of services	58%	64%	50%	69%	69%
Stigma	57%	60%	54%	65%	67%
Childcare/caregiver support	57%	62%	51%	60%	66%
No health insurance	54%	59%	47%	64%	71%
Transportation	54%	58%	48%	62%	62%
Inconvenient appointment times	53%	56%	50%	62%	65%
Not sure where to get help	53%	59%	47%	62%	69%
Appointment availability	53%	58%	48%	60%	70%
Language barriers	42%	48%	36%	53%	66%
Access to technology	40%	46%	34%	50%	60%
Cultural misunderstanding	40%	49%	29%	47%	63%

fourths of those experiencing housing needs identified appointment availability (n=178) and lack of insurance (n=183) as significant barriers to care. Service costs were the highest rated barrier for individuals with mental health or substance use needs (n=136) (Table 2).

Write-in responses from survey respondents (N=223) and comments from listening session participants provide valuable context for the previously described access challenges and indicate additional barriers to mental health and substance use services. The collective feedback from these participants fell into five main themes.

**Structural and Logistical Hurdles.** Participants identified several practical and financial obstacles as hindering their access to and ability to sustain services. Key barriers included restrictive service hours, long waitlists, service costs, insurance limitations, complex service requirements, and excessive paperwork. Lack of reliable transportation was a particularly challenging issue emphasized by many participants, especially for residents in South County who described having to travel long distances for services with limited transportation options.

*"Business hours do not match community needs (no weekend or after hours for families and their children)."*

**System Navigation.** Participants highlighted the difficulty of finding and navigating a complex, decentralized, and often unresponsive service network. Some participants reported not knowing where to start and feeling that there is a lack of information about where to get help or what services are available to them. This challenge is further complicated by geographic inequity, as most services are believed to be concentrated in Salinas, leaving rural and underserved communities with a perceived absence of local facilities.

**Workforce and Care Gaps.** Participants stressed the shortage of mental health professionals, which leads to limited appointment availability, long waitlists, and difficulties in establishing trust through consistent working relationships with a single provider. Participants also noted a lack of empathy and the feeling of not being believed by providers as key hindrances. Furthermore, the information silos between healthcare systems were noted as disruptions to care coordination and quality.

*"Lack of providers, and especially providers accepting new patients..."*

**Cultural & Linguistic Inaccessibility.** Participants reported a lack of cultural responsiveness and cultural competence among service providers. This includes the absence of adequate interpretation services and a shortage of therapists who reflect the community and understand cultural norms. Needs varied regionally, with South County listening session participants emphasizing the importance of Indigenous language services, while North County participants focused on the need for African American cultural representation.

*"I work with Indigenous families who often find it difficult to seek mental health support...They have expressed that staff sometimes appear frustrated when they request interpretation services..."*

**Stigma & Individual Readiness.** Participants highlighted factors that can prevent individuals from seeking help, even when services are physically available. Widespread personal and community-level stigma was emphasized as a major contributor to denying the need for help. Other factors included fear of seeking help due to potential consequences (such as

*"Stigma - from family, or from making [therapy] appointments for self."*

legal or immigration issues), confidentiality concerns, and a lack of individual readiness to engage in treatment.

## Housing Support Services

**Table 3. Barriers to Accessing Housing Support Services**

	High rent	High utilities cost	Insufficient income	No shared housing	Public housing criteria	Long waitlists
All Survey Respondents	85%	76%	83%	62%	69%	77%
Community Member	88%	81%	88%	65%	74%	81%
Provider	85%	84%	87%	74%	79%	82%
MH and/or SUD needs	88%	78%	85%	56%	67%	78%
Housing needs	87%	80%	81%	51%	72%	71%
Medi-Cal	87%	82%	87%	72%	80%	81%
Other Language	98%	99%	98%	98%	98%	98%

*Gold bar represents the top barrier for the identified subgroup*

High rent, insufficient income, long waitlists, and high utility costs emerged as the top obstacles to accessing housing services overall (76-85%) and across most subgroups. These and other barriers were notably higher among individuals with Medi-Cal insurance and those who spoke a language other than English or Spanish (typically Indigenous) (Table 3).

Additional insights into the challenges of accessing housing support services were gathered from open survey responses (N=212) and statements collected during listening sessions. This data was organized into the following six themes:

**Housing Scarcity.** The severe lack of affordable housing units was a barrier consistently highlighted by participants, who view this as the root of the housing crisis. The inventory shortage and resulting long waitlists are particularly pronounced in rural and underserved areas, where housing options are viewed as virtually nonexistent.

*"Housing availability in Monterey County and neighboring counties that is affordable does not exist..."*

**Financial Barriers and Economic Inequality.** Many participants noted how housing costs often exceed income in Monterey County. Insufficient wages and employment instability, often exacerbated by mental health and substance use challenges, can lead to inconsistent income. High move-in costs and credit score requirements further exclude potential applicants.

*"...The high cost of housing in Monterey County is another major problem..."*

**Systemic and Administrative Difficulties.** Participants highlighted procedural complexity and inefficiency as significant barriers to accessing housing services. Specific barriers noted included complex applications and documentation requirements, limited availability of services outside urban areas, and confusing referral processes. The lack of translation services and culturally competent staff, as well as the reliance on technology by services, makes the system further inaccessible for some populations.

*"...[The] system is too complicated. Requirements are ridiculously difficult. Feels like they try to discourage people from getting help."*

**Discrimination and Stigma.** Participants cited bias and fear among landlords and housing providers toward individuals with known mental health, substance use, or criminal histories as major obstacles. This was even more the case when this discrimination intersected with bias based on identity (e.g., LGBTQ+, racial minorities). Furthermore, strict credit score and income requirements were often viewed as administrative tools used to enable and validate such prejudicial attitudes.

*"...Not too many places take someone with a diagnosis of schizophrenia."*

**Insufficient Support Services and Resources.**

Participants noted the gap in comprehensive and tailored support that is necessary to maintain housing stability. Comprehensive services (such as integrated treatment and case management) for those with mental health and/or substance use challenges were specifically called out as lacking in addressing the complex needs of this population.

*"Most of the housing programs are for those with chronic mental health issues...[Referring to a program that used to serve SUD clients]...that housing does not have any services for those trying to stay sober. This has been a real loss for our community, and particularly for women with children."*

**Housing Instability as a Dual Challenge.** Listening session participants identified housing instability as both a cause that triggers or exacerbates behavioral health challenges and a consequence of those challenges. This complex barrier varied regionally, with South County focused on the lack of basic housing needs, while North County emphasized the limited availability of supportive housing options integrated with behavioral health services.

Collectively, these results showcase a range of barriers that limit or prevent access to services in Monterey County. Future planning should consider strategies that make services more responsive to community needs, creating a service environment where care is logistically feasible, culturally affirming, and capable of addressing multiple needs at once.

## Recommendations for Behavioral Health Services

Both survey respondents and listening session participants provided recommendations for enhancing housing interventions, treatment, and other services and supports for those experiencing behavioral health challenges. These suggestions are organized to align with BHS funding categories, offering potential ideas for future programming.

### Housing Interventions

Survey respondents were asked to rate strategies they believed would help individuals living with substance use and/or mental health issues find consistent housing. There was a strong consensus around expanding supportive housing services for individuals with behavioral health issues overall and across most subgroups. However, a few distinct differences were identified by insurance type. Those insured by Medicare (n=34) valued developing housing projects, while uninsured individuals (n=16) preferred programs focused on rental assistance (table 4).

**Table 4. Housing-Support Strategies for Individuals with Substance Use and/or Mental Health Challenges**

	Develop housing projects	Expand supportive housing	Budgeting/financial planning	Rental assistance
All	73%	81%	64%	72%
Community Member	78%	85%	72%	80%
Provider	94%	91%	75%	82%
MH and/or SUD needs	68%	82%	56%	67%
Housing needs	64%	75%	57%	69%
Family of a person with needs	64%	81%	51%	69%
Disability or chronic health condition	67%	78%	55%	69%
Survivor of domestic violence and/or sexual assault	60%	76%	75%	75%
LGBTQ+	79%	83%	65%	73%
Youth (0-25)	73%	84%	48%	73%
Adult (26-59)	74%	82%	66%	72%
Older Adult (60+)	73%	80%	62%	73%
Medicare	71%	67%	52%	50%
MediCal	82%	84%	70%	80%
Private Insurance	71%	86%	59%	72%
Uninsured	68%	73%	50%	73%
Prefer Not to Answer	48%	71%	71%	58%
English	68%	78%	47%	73%
Spanish	73%	73%	59%	57%
English and Spanish	68%	78%	64%	64%
Other Language	88%	97%	94%	89%
Prefer Not to Answer	43%	71%	86%	71%

**Gold bar** represents the top housing-support strategy for the identified subgroup

Additional housing support recommendations related to service delivery, funding, policy, and individual care were captured in the following four themes.

**Housing Supply and Financial Solutions.** Participants called for both increasing the physical housing

*"There has to be a way to impose rent control on more properties or property management groups because no matter how much you increase services and decrease judgement there is nothing that can be done if there are not available and affordable units."*

supply and providing direct financial assistance. Strategies like investing in public housing, implementing rent control, and limiting vacation rentals were proposed to address the key issue of insufficient affordable housing. Participants recommended housing vouchers and rental assistance programs as financial support.

Additionally, specialized, transitional, and trauma-sensitive housing strategically placed near essential services was also suggested.

**Systemic And Policy-Level Change.** Several recommendations emphasized the need to engage the broader community, local government, and anti-discrimination advocates to achieve necessary legal and policy changes. Participants stressed the importance of systemic accountability to ensure fair housing practices and policies, rather than focusing solely on interventions for individual agencies or clients.

*"This is a COMMUNITY responsibility... This problem will persist until this becomes a shared responsibility. We need to get local mayors, city officials, county district reps involved..."*

**Long-term Support and Skills Development.**

Participants highlighted the importance of sustained support after initial housing placement to ensure stability. Recommendations emphasized the provision of personalized support over extended periods. This includes offering essential skill-building opportunities (such as financial literacy and job training), providing family support services, and utilizing long-term housing navigators to help individuals manage their tenancy and resources successfully.

*"There should be ongoing, hands-on support to help people with mental health or substance use challenges secure and maintain housing... Case managers or mentors could guide them step by step, while also encouraging participation in workshops or manageable programs that build responsibility, consistency, and independence..."*

## Behavioral Health Services and Supports

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Listening session attendees offered strategies for strengthening the infrastructure and full continuum of behavioral health services in the community. The suggestions align with the goals of the Behavioral Health Services and Support component of BHSA and are summarized across the following four themes.

*"Community Health Workers – they were amazing during COVID. This was more effective over 2 years than the previous decade in connecting people [to] services."*

**Community-Based Support.** Participants recommended leveraging community-driven and peer-support models for service delivery, including system navigation. They also emphasized the need to partner with local community-based organizations as established, trusted resources.

**Crisis and Prevention Services.** Participants underscored the importance of services like Mobile Crisis Response Teams, which enable intervention before situations escalate to the point where law enforcement involvement is required. They believed greater crisis and prevention services would lead to safer and more appropriate support for individuals experiencing mental health issues.

*"We need help for people who have [mental health] issues before they get violent, so [Law Enforcement] doesn't have to get involved."*

**Youth and Family-Focused Services.** Participants recommended comprehensive youth prevention and early intervention services both in schools and the community. Support programs tailored to the needs of families were also suggested. Many emphasized the importance of including cultural components in these efforts.

*"Programs for youth addressing substance use and alcohol."*

*"...Transportation would help make services more accessible."*

**Transportation Solutions.** Participants called for direct transportation assistance, such as bus tickets or shuttle programs, to increase service accessibility.

**Cultural Responsiveness and Language Accessibility.** Survey respondents and listening session attendees recommended aligning the behavioral health workforce and service delivery model to the County's diverse cultural composition through the following sub-themes:

**Workforce Representation.** A priority for participants was the hiring of care providers who reflect the backgrounds of the clients they serve. Participants emphasized the importance of cultural representation for accurate diagnosis and effective treatment.

*"African American males who are suffering with mental health challenges need to be served by people who look like them."*

**Language Support.** Many participants noted the delay in care caused by language barriers. Hiring of Spanish-speaking bilingual staff and providers, as well as increased Indigenous language translation and interpretation services, especially in South County, was frequently recommended.

*"Important to have staff who speak Triqui and Mixteco, since many residents in Greenfield belong to those communities."*

**Cultural Competence.** Participants emphasized the importance of enhancing staff's ability to understand and interact with individuals from diverse cultural backgrounds across the continuum of care, ensuring effective and relevant care for all community members.

*"Culturally responsive services: Ensure housing programs integrate bilingual staff and culturally grounded approaches..."*

## Full-Service Partnership Services

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Listening session attendees also emphasized the importance of integrated, easy-to-access care that can meet complex needs, echoing the goals of the Full-Service Partnership Services component of BHSa. Their recommendations centered on the single theme below.

*“While the Housing First model may seem an equitable solution, without addressing the person’s MH and SUD concerns/issues, being able to maintain a stable and sustaining housing situation has proved to be unattainable...”*

**Housing with Wraparound Care.** Participants recommended co-locating comprehensive behavioral health services with housing. They stressed the importance of simultaneously addressing mental health, substance use, and housing, as housing alone is unsustainable if underlying behavioral health issues are not

resolved. The suggested integrated services included behavioral health treatment, case management, and workforce development to address multiple critical needs at once.

## Participant Demographics

Characteristics of CPPP participants were collected to ensure that insights gained through the Community Health Survey and Listening Sessions reflected the distinct populations residing in Monterey County. A total of 535 participants provided demographic information.

**Age.** The average age of survey participants was 40 years, with a range of 14 to 87 (see Table 5).

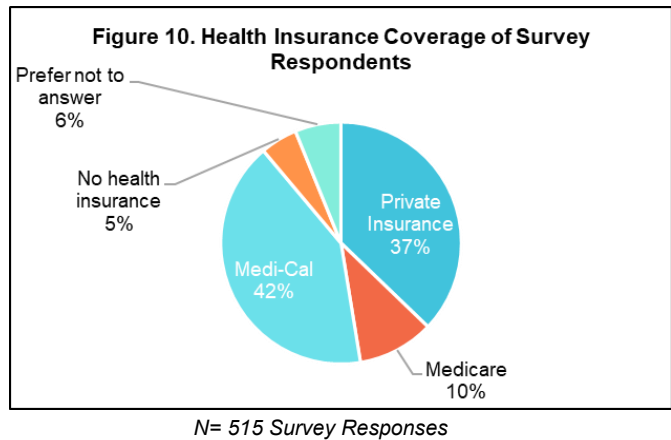
Age Category (n= 480)	Percentage
0-25 years	19%
26-59 years	68%
60+ years	13%
Prefer not to answer	0%

Ethnicity and Race (n= 454-540)	Percentage
American Indian or Alaska Native	1%
Asian	4%
Black or African American	6%
Hispanic or Latino	83%
Native Hawaiian or Pacific Islander	2%
Non-Hispanic or Latino	13%
White	21%
Another Race <sup>◇</sup>	1%
Prefer not to answer – Ethnicity	4%
Prefer not to answer – Race	5%

**Ethnicity and Race.** Over three-fourths of survey participants identified as Hispanic or Latino (83%).

\*Survey participants could select more than one race. Percentages exceed 100%  
<sup>◇</sup> Another Race included Bi-racial.

**Health Insurance.** The majority of survey participants reported having Medi-Cal insurance (42%; see Figure 10).



**Table 7. Gender Identity of Survey Participants\***

Gender Identity (n= 530)	Percentage
Genderqueer	1%
I prefer to self-describe <sup>◊</sup>	<1%
Man	23%
Questioning/Unsure of Gender Identity	0%
Transgender	<1%
Woman	75%
Prefer not to answer	2%

**Gender Identity.** Three-fourths of survey participants identified as women (Table 7).

\*Percentages exceed 100% due to rounding.

◊ Responses to 'I prefer to self-describe' included non-binary.

**Table 8. Sexual Orientation of Survey Participants\***

Sexual Orientation (n= 502)	Percentage
Bisexual	6%
Gay or Lesbian	2%
Heterosexual or Straight	65%
I prefer to self-describe <sup>◊</sup>	<1%
Queer	2%
Questioning/Unsure of Sexual Orientation	0%
Prefer not to answer	27%

**Sexual Orientation.** Approximately two-thirds of survey participants (65%) identified as heterosexual or straight (Table 8).

\*Percentages exceed 100% due to rounding.

◊ Responses to 'I prefer to self-describe' included non-binary.

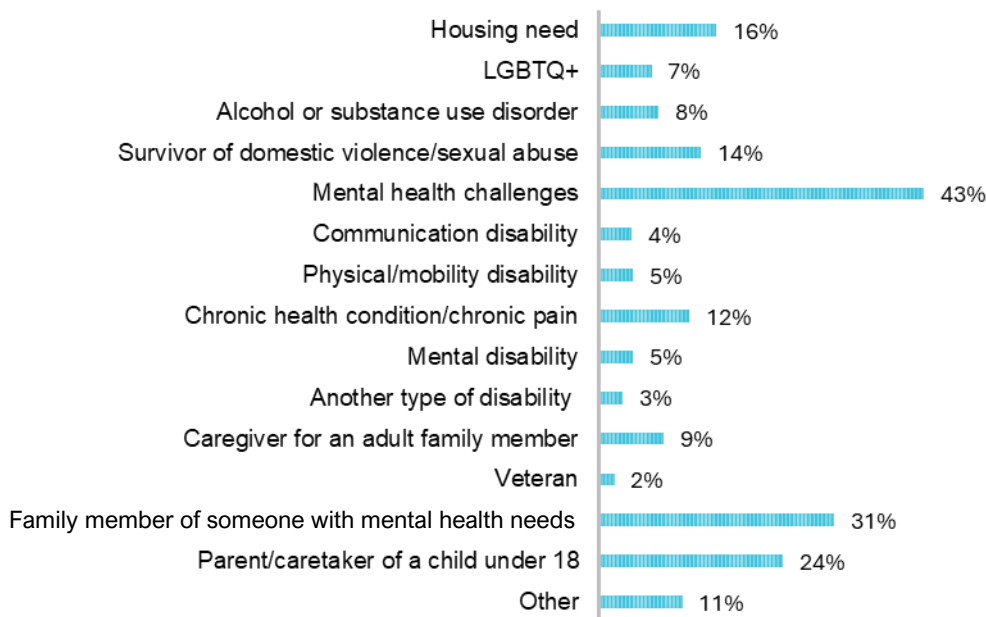
**Primary Language Spoken.** Survey participants were asked about the language they primarily spoke at home to better understand the language they used most frequently in their communication. Nearly half indicated Spanish was the main language used at home (Table 9).

Table 9. Primary Language of Survey Participants	
Gender Identity (n= 535)	Percentage
Both English and Spanish	14%
English	40%
Spanish	20%
Another language <sup>o</sup>	24%
Prefer not to answer	1%

<sup>o</sup>Another language included Triqui, Igbo, Arabic, Mixteco, Chatino, and Multilingual.

**Personal Identities.** To ensure the perspectives shared through the Community Health Survey were diverse and inclusive, survey participants were asked to share any additional personal identities they held. Almost half of the participants (43%) identified as individuals with mental challenges that affect their daily lives (Figure 11).

**Figure 11. Personal Identities of Survey Participants**



\*N=442 Survey Responses. Participants could select more than one identity. Sum of percentages may exceed 100%. Other identities included case workers, community workers, and behavioral health professionals. Participants reported the following disabilities and chronic health conditions, among others: Anxiety, Osteoporosis, undiagnosed depression, cirrhosis, and learning disability.

# Summary

Community Program Planning Process (CPPP) participants shared valuable insights on behavioral health issues, service gaps, and barriers to care in Monterey County (see table below). Findings indicate that perceptions of the care system vary depending on individuals' roles and experiences. Community Members, those who may need services, often view services differently from Providers who deliver or coordinate care. Subgroup analyses revealed greater variation within the community. Individuals with housing needs, behavioral health diagnoses (mental health and/or substance use disorder), and those who primarily speak Indigenous languages consistently reported distinct views on behavioral health concerns and services. These diverse viewpoints underscore the importance of culturally informed and tailored programming.

<b>Summary of Key Findings</b>	
<b>Top Behavioral Health Issues</b>	
<ul style="list-style-type: none"> <li>• Anxiety</li> <li>• Alcohol Use Disorder</li> <li>• Trauma</li> </ul>	
<b>Perceived Service Availability</b>	
<ul style="list-style-type: none"> <li>• Insufficient mental health and substance use services</li> <li>• Unavailable housing support services for those with mental health or substance use issues</li> </ul>	
<b>Communication Preferences</b>	
<ul style="list-style-type: none"> <li>• Social media</li> <li>• Email</li> </ul>	
<b>Perceived Service Accessibility</b>	
<ul style="list-style-type: none"> <li>• Low perceptions of:               <ul style="list-style-type: none"> <li>○ Accessible mental health and substance use services (~40%)</li> <li>○ Housing support for individuals experiencing these challenges (~21%)</li> </ul> </li> </ul>	
<b>Barriers to Services</b>	
<i>Mental Health and Substance Use Services</i>	
<ul style="list-style-type: none"> <li>• Cost of services</li> <li>• Lack of childcare/caregiver support</li> <li>• Stigma</li> <li>• Structural and Logistical Hurdles (e.g. like restrictive hours, cost, long waits, and lack of transportation)</li> </ul>	<ul style="list-style-type: none"> <li>• Navigating a complex, decentralized service network</li> <li>• Provider shortages</li> <li>• Inconsistent care</li> <li>• Individual readiness</li> <li>• Cultural &amp; Linguistic Inaccessibility</li> </ul>
<i>Housing Support Services</i>	
<ul style="list-style-type: none"> <li>• High rent</li> <li>• Insufficient income</li> <li>• Long waitlists</li> <li>• High utility costs</li> <li>• Cyclical relationship between housing instability and behavioral health issues</li> <li>• Lack of integrated services</li> </ul>	<ul style="list-style-type: none"> <li>• Economic factors (e.g. high costs, low income, housing requirements)</li> <li>• Lack of affordable housing</li> <li>• Discrimination and Stigma</li> <li>• Administrative Challenges (e.g. complex applications, poor referral processes)</li> </ul>

CPPP participants also offered recommendations for enhancing behavioral health services and support, providing ideas for future BHSA programming.

<b>BHSA Component</b>	<b>Recommendations</b>
<i>Housing</i>	<ul style="list-style-type: none"> <li>• Increase the County's affordable housing inventory</li> <li>• Expand housing support services for individuals with behavioral health conditions</li> <li>• Offer and strengthen financial assistance programs</li> <li>• Improve and streamline housing policies</li> <li>• Provide long-term support and skill-building opportunities</li> </ul>
<i>Behavioral Health Services and Supports</i>	<ul style="list-style-type: none"> <li>• Scale up community-based services and peer support models</li> <li>• Expand crisis and prevention services</li> <li>• Broaden the availability and types of services for youth and families</li> <li>• Hire and retain care providers who reflect the cultural and linguistic backgrounds of the communities served</li> <li>• Increase translation and interpretation services, with a priority on Indigenous languages</li> <li>• Enhance cultural competence among staff and providers</li> </ul>
<i>Full-Service Partnerships</i>	<ul style="list-style-type: none"> <li>• Integrate behavioral health care with housing services</li> <li>• Provide direct transportation assistance</li> </ul>

This Community Planning Process Report was created by EVALCORP in collaboration with Monterey County Behavioral Health.

